STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

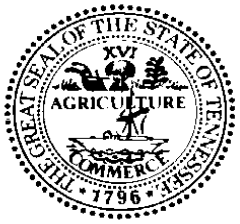
OF

UAHC HEALTH PLAN OF TENNESSEE, INC.

MEMPHIS, TENNESSEE

FOR THE PERIOD JANUARY 1, 2007
THROUGH JUNE 30, 2007

TABLE OF CONTENTS



STATE OTENNESSEE

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
TENNCARE DIVISION
500 JAMES ROBERTSON PARKWAY, SUITE 750
NASHVILLE, TENNESSEE 37243-1169

615-741-2677
Phone

615-532-8872
Fax

TO: Darin Gordon, Deputy Commissioner
Tennessee Department of Finance and Administration, TennCare Bureau

Leslie A. Newman, Commissioner
Tennessee Department of Commerce and Insurance

VIA: Gregg Hawkins, CPA, Assistant Director
Office of the Comptroller of the Treasury
Division of State Audit

Lisa R. Jordan, CPA, Assistant Commissioner
Tennessee Department of Commerce and Insurance

John Mattingly, CPA, TennCare Examinations Director
Tennessee Department of Commerce and Insurance

CC: M. D. Goetz, Jr., Commissioner
Tennessee Department of Finance and Administration

FROM: Gregory Hawkins, CPA, TennCare Examinations Manager
Ronald Crozier, TennCare Examiner
Shirlyn W. Johnson, CPA, TennCare Examiner
Steve Gore, CPA, TennCare Examiner
Jacqueline Laws, Legislative Auditor
Scott Waller, Legislative Auditor

DATE: February 12, 2008

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Market Conduct Examination of UAHC Health Plan of Tennessee, Inc., was completed December 6, 2007. The report of this examination is herein respectfully submitted.

I. FOREWORD

On October 10, 2007, the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) notified UAHC Health Plan of Tennessee, Inc. of its intention to perform a market conduct and limited scope financial statement and compliance examination. Fieldwork began on November 26, and ended on December 7, 2007.

This report includes the results of the market conduct examination "by test" of the claims processing system of UAHC. Further, this report reflects the results of a limited scope examination of financial statement account balances as reported by UAHC. This report also reflects the results of a compliance examination of UAHC's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of UAHC was conducted jointly by the TennCare Division of the TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement (CRA) between the State of Tennessee and UAHC, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-215 and § 56-32-232.

UAHC is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of UAHC. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statement as reported by UAHC on its National Association of Insurance Commissioners (NAIC) quarterly statement for the period ended June 30, 2007, and the Medical Services Monitoring Report filed by UAHC as of June 30, 2007.

The limited scope compliance examination focused on UAHC's provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with non-discrimination reporting requirements and the Insurance Holding Company Act.

Fieldwork was performed using records provided by UAHC before and during the onsite examination of records from November 26, 2007, through December 6, 2007.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that UAHC's TennCare operations were administered in accordance with the CRA and state statutes and regulations concerning HMO operations, thus reasonably assuring that the UAHC TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether UAHC met certain contractual obligations under the CRA and whether UAHC was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq.*;
- Determine whether UAHC had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;
- Determine whether UAHC properly adjudicated claims from service providers and made payments to providers in a timely manner;
- Determine whether UAHC had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and
- Determine whether UAHC had corrected deficiencies outlined in prior examinations of UAHC conducted by TDCI.

III. PROFILE

A. Administrative Organization

UAHC, formerly OmniCare Health Plan, Inc., was chartered in the State of Tennessee on October 6, 1993, for the purpose of providing managed health care services to individuals participating in the State's TennCare Program. UAHC is a wholly owned subsidiary of United American of Tennessee, Inc. (United American Tennessee) which is a wholly owned subsidiary of United American Healthcare Corp. (United American Detroit). On April 21, 2005, OmniCare Health Plan, Inc., requested modification to its Certificate of Authority (COA) to reflect the new corporate name UAHC Health Plan of Tennessee, Inc. On April 25, 2005, TDCI granted this modification with an effective date of March 21, 2005. UAHC contracts with United American Tennessee to provide management services.

Beginning January 1, 2007, UAHC began operations of a Medicare Advantage plan through a Special Needs Plan for eligible enrollees in Shelby County, Tennessee. The

plan is offered through a contract between UAHC and the Centers for Medicare & Medicaid Services.

The officers and board of directors for UAHC at June 30, 2007, were as follows:

Officers for UAHC
Stephanie Dowell, Chief Executive Officer
Stephen Harris, Chief Financial Officer
Myla Johnson, Vice-President Medical Services
Stacy Hill, Vice-President MIS
Edward Reed, M.D., Senior Vice President & Medical Director

Board of Directors for UAHC

Stephanie Dowell	Stephen Harris
Tom Goss	Samuel King
Grover Barnes, M.D.	Julius V. Combs, M.D.
Grisselle Figueredo, M.D.	Lloyd Robinson, M.D.
Logan Miller, M.D.	Neal Beckford, M.D.
Stan Sawyer	William Brooks
Attorney Ricky Williams	

B. Brief Overview

Effective July 1, 2002, the CRA with UAHC was amended to temporarily operate under a no risk agreement beginning July 1, 2002 through the current period. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. UAHC agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During September 2002, UAHC and the TennCare Bureau executed Amendment Number 3 to the CRA which expanded the no risk period. UAHC and TennCare agreed the payments under Amendment Number 3 would be limited to the amount necessary to reinstate UAHC's net worth to statutory requirements as of June 30, 2002. On August 28, 2007 UAHC reimbursed TennCare $455,193.21 for excess funding and submitted a final actuarial certification for the period July 1, 2001 through June 30, 2002 for amounts reimbursed through Amendment Number 3.

During stabilization, UAHC receives from the TennCare Bureau monthly fixed administrative payments based upon the number of TennCare enrollees assigned to UAHC. The TennCare Bureau reimburses UAHC for the cost of providing covered services to TennCare enrollees.

UAHC is currently authorized by TDCI and the TennCare Bureau to operate in the community service areas of Shelby County, Northwest Tennessee and Southwest Tennessee which comprise the West Grand Region. As of June 30, 2007, UAHC had approximately 107,800 TennCare members and 240 Medicare Advantage members.

C. Claims Processing Not Performed by UAHC

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy
- Behavioral Health

During the period under examination, UAHC subcontracted with the following vendor for the processing and payment of claims submitted by providers:

- Vestica HealthCare (formerly Doral USA) for medical claims processing

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by the TDCI TennCare Division for the period January 1, 2004 through December 31, 2004:

A. Financial Deficiencies

1. On December 20, 2004, the terms of the management agreement were not followed because United American Tennessee entered into a lease agreement with UAHC as the lessee. Operation by UAHC under the lease agreement was in a manner contrary to information submitted to TDCI to obtain and maintain its certificate of authority to operate as a HMO. The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operation documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1).

2. UAHC should improve the methodology utilized for the allocation of management fees to NAIC expense categories by initially identifying salaries and compensation incurred by United American Tennessee which are 100% related to UAHC or other operations. Direct costs that are related 100% to specific operations should be allocated to the specific operations before other pertinent ratios are applied.

3. UAHC recovered third party liability and subrogation of $79,914 through August 17, 2005 that had been previously reimbursed by the State through Amendment 3

funding. As of the examination fieldwork date, UAHC had not remitted any of these amounts to the State. As third party liability and subrogation amounts are recovered from no risk funding, UAHC should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered. An examination adjustment to net worth for $79,914 is required.

4. On the 2004 NAIC Annual financial statement, certificate of deposits of $3,605,000 were incorrectly reported as bonds. Certificates of deposits depending on a maturity date either less than one year or greater than one year should be reported either as cash and cash equivalents or other invested assets, respectively.

5. UAHC and TennCare agreed the payments under Amendment Number 3 would be limited to the amount necessary to reinstate UAHC's net worth to the statutory net worth requirement as of June 30, 2002. UAHC's reported net worth on the NAIC June 30, 2002 financial statement was $385,729 in excess of the statutory net worth requirement and, thus, should be returned to TennCare. Additionally, UAHC should submit a final actuarial certification for the period July 1, 2001, through June 30, 2002 for amounts reimbursed through Amendment 3. After the actuarially certified excess funding is determined, additional amounts payable to TennCare may be required.

6. UAHC reported $47,540 in income tax expense on the 2004 NAIC Annual financial statements. The reported income tax expense is based upon UAHC's allocated portion of income tax expense as part of United American Detroit's consolidated tax return. However, UAHC did not seek the required prior approval by TDCI for transactions within a holding company. Additionally, NAIC Statement of Statutory Accounting Principles No. 10 requires where the plan files a consolidated tax return with one or more affiliates, income tax transactions between the affiliated parties can only be recognized pursuant to a written tax allocation agreement.

   Finding number three is repeated in this current examination.

B. <u>Claims Processing Deficiencies</u>

1. For all medical and vision processed claims, UAHC did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the months of March 2005, April 2005 and June 2005.

2. During examination test work to verify the accuracy of data files submitted to TDCI, it was discovered that UAHC failed to include the processed claims by the subcontractor for vision claims, Block Vision. After several attempts, UAHC was able to obtain data files from Block Vision in the proper format for prompt pay testing. Data for each month was tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. § 56-32-226(b)(1). Separate analyses of claims processed revealed Block Vision was unable to meet prompt pay requirements for June, August, September, and October 2005 in accordance with Tenn. Code Ann. § 56-32-226(b)(1).

3. UAHC failed to comply with the claims payment accuracy requirements of Section 2-9. of the CRA for the second quarter 2004, third quarter 2004, fourth quarter 2004, first quarter 2005, third quarter 2005, and fourth quarter 2005.

4. The following deficiencies were noted in the preparation of the claims payment accuracy reports and procedures to follow-up on deficiencies noted in the claims payment accuracy testing:

   - UAHC and Vestica corrected only claims identified as errors from the 300 claims selected for testing in each quarter. The errors identified by UAHC were the result of improper establishment of the claims processing system payment logic. Testing should have been expanded immediately to determine if other claims paid applied similar incorrect system payment logic. As a result of this failure to follow-up on incorrect system payment logic, material overpayments have occurred. UAHC must correct all overpayments when discovered. Sections 2.9.g.9., Claims Processing Requirements, and 4-3., Errors, of the Contractor Risk Agreement address specifically UAHC's responsibility to recover overpayments and errors. Testing of claims overpayments by TDCI was expanded. As noted below, UAHC agreed to an expanded medical claim overpayment review by a separate vendor operating under the oversight of TDCI to encompass all claims paid since UAHC went into stabilization in May 2002.

   - Block Vision claims were not included in the population from which the claims were sampled until the third quarter 2005 report. All claims processed should be included in the population from which claims are to be selected for testing.

   - The method for selecting claims each month did not include all claim types based on claims forms. Claim types in the processing system are either on HCFA1500 or UB92 claims forms. In January 2005, UAHC only tested claims submitted on HCFA 1500 claims forms. In February 2005, UAHC only tested claims submitted on UB92 claims forms. UAHC should test both types of claims forms for each month tested.

   - The work papers for the third quarter 2005 claims payment accuracy report do not leave a sufficient audit trail because the "results for each attribute tested for each claim selected" was not maintained for inspection.

5. Based upon the initial medical claims overpayment review for the period May 1, 2002 through June 30, 2005, claims overpayments by UAHC of $5,515,225 were identified. UAHC disputed this total and after the release of the previous examination report TDCI agreed to reduce the claims overpayment amount by $1,289,291.33 to $4,225,933.67. Of this amount, UAHC recouped from providers and returned to TennCare $3,215,784.91. For the remaining $1,010,148.76, an escrow account established between UAHC and TennCare was utilized to return medical overpayments to TennCare. For the period July 1, 2005 through June 30, 2006, the medical overpayment review determined overpayments of $1,132.323.92 had occurred. UAHC agreed to the calculated overpayments and returned to TennCare the overpayments through provider recoupments. The previous finding recommended

UAHC should continue to improve claims payment accuracy percentages. Monitoring of the claims processing subcontractor should be enhanced. Benefit rules and claims processing system logic should be consistently and correctly applied. UAHC should ensure that all fee tables and disbursement methodologies are accurately configured in Vestica's claims processing system.

As part of the current examination, testing was expanded to determine if UAHC has addressed issues in the previous claims overpayment reviews.

6. Deficiencies in claim processing by Block Vision were noted. The validity of all procedure codes reported by Block Vision could not be verified by TDCI. Additionally, claims were incorrectly processed because the diagnosis code was for medical services instead of vision services.

   Finding number one is repeated in this current examination.

C. Compliance Deficiencies

1. For two of the three provider contracts selected for testing, amendments to both contracts were not submitted to TDCI for prior approval as a material modification to UAHC's certificate of authority as required by Tenn. Code Ann. § 56-32-203(c)(1). UAHC should submit any amendments to approved provider contract templates for prior approval by TDCI.

2. UAHC operated under the Block Vision subcontract without the prior approval of TDCI. A letter from TDCI on February 23, 2003, advised UAHC that its submission of the material modification of the Block Vision subcontract was deficient. No response was made to correct the deficiencies noted.

3. Both of the subcontractors for claims processing experienced significant deficiencies. Claims payment accuracy percentages failed to meet CRA requirements of 97%. UAHC internal audits and the medical claims overpayment review noted material overpayments as a result of the claims processing system payment logic. Vision claims were not processed timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1). TDCI recommends that UAHC implement the following procedures to improve the monitoring of subcontractors:

   - When the internal auditor notes deficiencies by the subcontractor, testing should be expanded to determine if other claims paid have applied similar incorrect system payment logic.

   - The testing for claims payment accuracy by UAHC's internal auditor did not identify all of the deficiencies noted by the claims consultant. To ensure that the internal auditor does identify deficiencies in the future, the internal audit department should supplement claims payment accuracy testing with similar computerized audit techniques utilized by the claims consultant. These techniques can be designed to search for payment errors such as duplicate payments made by the subcontractor. Several auditing software packages are available by outside vendors. A key to applying computerized audit techniques is

to have an accurate data warehouse. TDCI found that UAHC's data warehouse of previously processed claims was incomplete since it did not include adjusted claims.

- UAHC should clearly document the business rules for the subcontractor to utilize in processing claims. During the medical claims overpayment review, it was discovered the subcontractor was applying old business rules previously supplied by UAHC.

- UAHC should complete an audit of all fee tables loaded in the claims processing system. During the medical claims overpayment review, errors continued to be found in the fee tables established in the claims processing system as compared to contracted provider rates. In many instances, the subcontractor relied upon e-mails sent from UAHC officials to determine the appropriate payment rates.

- UAHC should gain a clearer understanding of the claim processing system utilized by the subcontractor. At the beginning of fieldwork, UAHC's only access to the subcontractor's claims processing system was through a limited web inquiry. The web inquiry was insufficient since it did not allow UAHC to review relevant modules of the subcontractor's claims processing system including member eligibility, provider maintenance, authorization system, fee tables and other processing modules. During the medical claims overpayment review, the claims consultant and UAHC gained the necessary access to the subcontractor's claims processing system through inquiry-only mode.

4. The following deficiencies were noted in UAHC's internal audit department:

   - Although the internal auditor noted significant deficiencies in claims payment by the claims processing subcontractor, UAHC did not expand testing to determine if other claims paid have applied similar incorrect system payment logic. As a result of this failure to follow-up on incorrect system payment logic, material overpayments occurred. UAHC should establish procedures to carefully consider noted errors by the internal auditor and appropriately research if others claims were incorrectly processed in the same manner.

   - The procedures to prepare claims payment accuracy reports were deficient because of inadequate sample selection methods and the failure to maintain sufficient audit trail of attributes tested.

   - The internal auditor should also perform focused reviews to determine UAHC's compliance with CRA requirements including the conflict of interest requirements.

5. In 2005, several media reports linked former State Senator John Ford to UAHC and possible violations of conflict of interest requirements of the CRA. Sections 4-7. of the CRA warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to UAHC in connection with any work contemplated or

performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration. On April 15, 2005, United American Detroit stated it contracted with former State Senator John Ford for consulting services to "explore expansion of its business to other southern states beyond Tennessee…" The State Attorney General's Office, Tennessee Registry of Election Finance, and the Tennessee Bureau of Investigation have initiated investigations into the transactions between United American Detroit and former State Senator John Ford.

UAHC agreed to deposit into escrow with TennCare $420,500 for the amounts paid to former State Senator John Ford. In depositing such amount into escrow, UAHC specifically denied that it has in any way breached the CRA and affirms that it is making the payment in good faith for the security of TennCare. As of the release of this examination report, investigations of payments by United American Detroit to former State Senator John Ford and possible violations of conflict of interest requirements of the CRA have not been concluded. The escrow deposit for $420,500 remains in effect.

TDCI recommends that UAHC, United American Tennessee and United American Detroit implement the following procedures to enhance compliance with the CRA including conflict of interest requirements:

- Since the only HMO controlled by United American Detroit is UAHC, the TennCare plan, members of the board of directors and officers of United American Detroit should be held to the same annual reaffirmation of the code of conduct disclosures required by employees of the management company. The directors and officers of United American Detroit have the same responsibility as United American Tennessee employees to ensure compliance with all of the terms of the CRA.

- This examination report included multiple deficiencies in TennCare operations including overpayment of Federal and State dollars and failures in the monitoring of subcontractors. The board of directors and the officers of UAHC and United American Detroit's oversight of UAHC should focus on the correction of deficiencies in TennCare operations.

- Internal audit department should perform focused reviews to determine UAHC's compliance with CRA requirements including the conflict of interest requirements. Through internal audit, the board of directors should ensure that management adheres to internal controls established.

Finding number two is repeated in this current examination.

V. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The detail of testing as well as management's comments to each finding can be found in Sections VI, VII, and VIII of this examination report.

A. Financial Deficiencies

1. Reported cash and payables due to TennCare are both understated by $409,603.87 on the 2007 NAIC Second Quarterly Statement. The cash and payables due to TennCare were incorrrectly offset against each other before being reported on the NAIC statement. The payable due to TennCare is for subrogation recoveries and provider refund checks due to TennCare for the no-risk period. The correcting entry to increase cash and payables due to TennCare will not effect reported net income or net worth. (See Section VI A.4.)

2. UAHC incorrectly classified $500,000 in certificates of deposit as "Other Invested Assets" on the 2007 NAIC Second Quarterly Statement. Per NAIC instructions, the line item for "Cash and Cash Equivalents" should include certificates of deposit. The reclassification of the certificates of deposits from "Other Invested Assets" to "Cash and Cash Equivalents" will not effect reported net income or net worth. (See Section VI.A.5.)

3. UAHC incorrectly reported the change in non-admitted assets as $120,000 on the Statement of Revenue and Expenses, Page 2, on the 2007 NAIC Second Quarterly Statement. No change in non-admitted assets from December 31, 2006 through June 30, 2007 occured. UAHC did amend the Statement of Revenue and Expenses to correctly report the change in non-admitted assets as well as reconcile capital and surplus accounts from the period December 31, 2006 through June 30, 2007. (See Section VI.A.6.)

4. UAHC incorrectly classified $94,606 as marketing expenses in the general ledger and on the TennCare Operating Statement for the period ending June 30, 2007. These valid expenses related mostly to production of member identification cards and should not be classified as marketing. The reclassification of these expenses will not affect reported net income or net worth. (See Section VI.A.7.)

5. In preparation of the TennCare Operating Statements, inpatient hospital expenses were overstated by $427,136 since these expenses were related to UAHC's Medicare line of business. UAHC correctly amended the TennCare Operating Statement on December 12, 2007, to correctly report inpatient hospital expenses for the period January 1 through June 30, 2007. The correction did not effect reported net income or net worth because of the deviation required for reporting the TennCare Operating Statement. (See Section VI.C.)

6. On August 6, 2007, UAHC executed for the Medicare Advantage plan membership an excess insurance policy. This stop loss policy pays for medical expenses exceeding the agreed upon amount defined in the policy. This particular contract represents an excess or aggregate insurance policy as defined in Tenn. Code Ann. § 56-32-203(d). The plan failed to submit the policy to TDCI

for prior approval as required by Tenn. Code Ann. § 56-32-203(c)(1). (See Section VI.E.)

B. Claims Processing Deficiencies

1. UAHC did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the months of January and March 2007.

2. For procedures to prepare claims payment accuracy reports, the following deficiencies and recommendations were noted:

   - TDCI recommends UAHC develop a more formalized process to resolve system and manual errors. The process should include documentation that all claims related to error issues were researched, approved by appropriate personnel and the results of recoupments or additional payments documented. The subcontractor should provide affirmation that the problem was corrected through the claims processing system. (See Section VII.D.2.)

   - UAHC and Vestica should increase controls over the loading of provider rate configurations. One of the error claims found through UAHC's internal audits found that the person responsible for provider rate configuration incorrectly entered the contracted rate percentage. Additional review and approval should be performed to confirm when rates are entered they agree with the terms of the executed contract. (See Section VII.D.2.)

3. The data elements recorded on the claims were compared to the data elements entered into UAHC's claims processing system. A discrepancy was noted for one of the ninety claims selected for testing by comparing the information submitted on the claims and the data recorded in UAHC's system. The date of service was incorrectly entered into the claim processing system which also resulted in an incorrect denial for untimely filing. (See Section VII.F.)

4. For five of the ninety claims selected for testing, the following processing errors were noted. (See Section VII.G.)

   - For one claim, UAHC incorrectly denied the claim with the explanation reason "invalid modifier". The modifier reported by the provider was appropriate for the medical procedure. UAHC reprocessed and paid the claim on December 6, 2007.

   - For one claim, code J0886 reported by the provider with procedure code Q4081. Procedure code J0886 was invalid for the date of service and should have been denied. Additionally, since UAHC changed the procedure code on the claim, a second claim was paid for the same service in error. UAHC recouped the duplicate payment on November 15, 2007. UAHC should research other payments for these procedure codes to verify duplicate payments have not occurred.

- For one claim, the date of service was incorrectly entered into the claims processing system which resulted in an incorrect denial for timely filing.
- For one claim, UAHC incorrectly paid a duplicate claim for the same member, and date of service on October 25, 2007. UAHC recouped the overpayment on November 21, 2007. UAHC noted the duplicate was the result of the submission of an electronic claim and a paper claim for transplant services. UAHC should work with Vestica to develop procedures to eliminate duplicate payments when an electronic and paper claim is submitted for transplant services.
- For one claim, UAHC's denial of the claim was appropriate but the explanation reason communicated to the provider "no reimbursement information found for service" did not reflect the reason the claim denied. The reason the claim denied was that the provider had not submitted all documents related to credentialing.

5. For two of the ninety claims selected for testing, the following pricing errors were noted. (See Section VII.H.)
   - For one claim, UAHC underpaid a hospital provider because the claim was paid based on a per diem instead of the contracted case rate.
   - For one claim, the payment amount by other insurance was incorrectly entered resulting in an overpayment of $0.83.

C. Compliance Deficiencies

1. Ten provider complaints were selected for testing from provider complaint logs to determine if responses were timely. For one of the ten provider complaints tested, the provider was informed of the resolution to the complaint 62 calendar days after receipt of the provider's reconsideration request. The additional time to completely respond was not agreed upon in writing by the provider and UAHC as required by UAHC's policy and Tenn. Code Ann. § 56-32-226 (See Section VIII.A.)

2. UAHC has submitted for prior approval to TDCI a provider contract template which includes a standard compensation exhibit. Review of executed provider contracts found that the approved standard compensation exhibit was not always utilized. All compensation terms should have been submitted to TDCI for prior approval as required by Section 2-9 of the CRA and Tenn. Code Ann. § 56-32-203(c)(1).

3. Section 2-18. of the CRA between UAHC and TennCare requires specific language requirements for provider agreements. For five of seven provider agreements selected for testing, not all of the contract language requirements were included in the executed contracts. (See Section VIII.C.)

4. UAHC executed a subcontract for a nurse help line without prior approval of the TennCare Bureau and TDCI in violation of Sections 2.9.f. and 2-17.c. of the CRA and Tenn. Code Ann. § 56-32-203(c)(1). (See Section VIII.E.)

5. UAHC amended the administrative service agreement with Vestica for claims processing services. The amendment added the processing for the Medicare line of business and adjusted the compensation to Vestica. Since the amendment included more than a change in compensation amount, the amendment should be submitted to TDCI for approval per Tenn. Code Ann. § 56-32-203(c)(1).(See Section VIII.E.)

6. Subrogation amounts collected through June 30, 2007 totaling $409,603.87 were not returned to the State in a timely manner per Sections 3-10.h.2.(f) and (g) of the CRA. The amount collected was not reduced from the next reimbursement request to the TennCare Bureau. A majority of the amounts collected and due to TennCare were over 90 days old. UAHC should improve procedures to promptly analyze and record these amounts into the claims processing system. (See Section VIII.K.5.)

7. Two of the seven contracts did not include conflict of interest language requirements per 2-18.cc. of the CRA. UAHC indicates that the agreements for these providers incorporate by reference the provider manual to enforce the conflict of interest language. The provider manual does include the conflict of interest language requirements. However, UAHC has not provided proof of notice of rejection per Section 2-18.cc. (See Section VIII.L.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, UAHC is required to file annual and quarterly NAIC financial statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if UAHC meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because “admitted” assets must be easily convertible to cash, if necessary, to pay outstanding claims. “Non-admitted” assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At June 30, 2007, UAHC reported $16,967,646 in admitted assets, $5,473,142 in liabilities and $11,494,504 in capital and surplus on its 2007 NAIC 2nd Quarterly Statement submitted September 4, 2007. UAHC reported total net income/(loss) of ($354,871) on its statement of revenue and expenses. The filing was amended by UAHC after fieldwork on December 12, 2007, to reflect audit adjustments by UAHC's external auditor. The adjustments by the external auditor did not effect reported net worth.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires UAHC to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

2007 Statutory Net Worth Calculation

UAHC's premium revenue per documentation obtained from the TennCare Bureau totaled $232,055,642 for the calendar year 2006; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), UAHC's statutory net worth requirement for the calendar year 2007 is $7,230,835. UAHC reported total capital and surplus on the amended 2007 NAIC Second Quarterly Statement of $11,494,504 as of June 30, 2007, which is $4,263,669 in excess of the minimum statutory net worth requirement.

TennCare Premium Revenue for the Examination Period

For the examination period January 1 through June 30, 2007, the following is a summary of UAHC's premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2):

Administrative fee payments from TennCare for the period January 1 through June 30, 2007	$7,585,135
Reimbursement for medical payments from TennCare for the period January 1 through June 30, 2007	$104,611,749
Reimbursement for premium tax payments from TennCare for the period January 1 through June 30, 2007	$2,354,913
Total TennCare premium revenue January 1 Through June 30, 2007	$114,551,797

2. Restricted Deposit

Beginning July 1, 2005, an amendment to the CRA required TennCare MCOs to have on deposit an amount equal to the calculated statutory minimum net worth requirement. Based upon premium revenues for calendar year 2006 totaling $232,055,642, UAHC's statutory deposit requirement at June 30, 2007 was $7,230,835. UAHC had on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $7,580,000 had been pledged for the protection of the enrollees in the State of Tennessee.

3. Claims Payable

As of June 30, 2007, UAHC reported $464,567 claims unpaid on the NAIC annual statement. This amount represents an estimate of unpaid claims or incurred but not reported (IBNR) for only Medicare operations that began January 1, 2007. No amount is reported as claims unpaid for TennCare operations. This appears reasonable since UAHC's TennCare operations have been operated as no-risk because of Amendment 3 previously discussed. Review of the triangle lag payments for Medicare operations after June 30, 2007, through November 30, 2007, for dates of services before July 1, 2007, determined that the reported claims payable appears reasonable.

4. Cash and Payable Due to TennCare

Reported cash and payables due to TennCare are both understated by $409,603.87 on the 2007 NAIC Second Quarterly Statement. The cash and payables due to TennCare were incorrectly offset against each other before being reported on the NAIC statement. The payable due to TennCare is for subrogation recoveries and provider refund checks due to TennCare for the no-risk period. The correcting entry to increase cash and payables due to TennCare will not effect reported net income or net worth.

Management Comments

This has been the established accounting policy of UAHC-TN, since the execution of Amendment 3 and implementation of the TennCare Administrative Services Arrangement in July 2002. We have made the change in our accounting policy, and the change was made in the amended second quarter NAIC statement filed on December 12, 2007.

5. Other Invested Assets

UAHC incorrectly classified $500,000 in certificates of deposit as "Other Invested Assets" on the 2007 NAIC Second Quarterly Statement. Per NAIC instructions,

the line item for "Cash and Cash Equivalents" should include certificates of deposit. The reclassification of the certificates of deposits from "Other Invested Assets" to "Cash and Cash Equivalents" will not effect reported net income or net worth.

Management Comments

UAHCTN concurs with TDCI's finding. The correction was made in the amended second quarter NAIC statement filed on December 12, 2007.

6. Change in Non Admitted Assets

UAHC incorrectly reported as the change in non-admitted assets as $120,000 on the Statement of Revenue and Expenses, Page 2, on the 2007 NAIC Second Quarterly Statement. No change in non-admitted assets from December 31, 2006 through June 30, 2007 occured. UAHC did amend the Statement of Revenue and Expenses to correctly report the change in non-admitted assets as well as reconcile capital and surplus accounts from the period December 31, 2006 through June 30, 2007.

Management Comments

UAHCTN concurs with TDCI's finding. The correction was made in the amended second quarter NAIC statement filed on December 12, 2007.

7. Marketing Expenses

UAHC incorrectly classified $94,606 as marketing expenses in the general ledger and on the TennCare Operating Statement for the period June 30, 2007. These valid expenses related mostly to production of member identification cards and should not be classified as marketing. The reclassification of these expenses will not affect reported net income or net worth.

Management Comments

UAHCTN concurs with TDCI's finding. The correction was made in the amended second quarter NAIC statement filed on December 12, 2007.

B. Escrow Agreements

The previous examination for the period ending December 31, 2004 noted the existence of two escrow agreements between TennCare and UAHC, or United American TennesseeTransactions and current status of the escrow agreements are as follows:

1. UAHC funded in August 2005 an escrow account held by TennCare in the

amount of $2,300,000. The escrow was established as security pending the results of a medical claims overpayment review by TDCI for the periods May 1, 2002 through June 30, 2005, and July 1, 2005 through June 30, 2006. As of May 18, 2007, TDCI and UAHC has agreed to the amounts determined as medical overpayments except for $1,010,149. TennCare permitted the reduction of this escrow account from $2,300,000 to the $1,010,149 disputed amount. TennCare reviewed separately the disputed overpayment and agreed with TDCI's determination. On November 26, 2007, the plan agreed to release to TennCare the remaining escrow amount of $1,010,149 to repay the overpayment.

2. The other escrow account in the amount of $420,500 relates to payments made to former State Senator John Ford by a parent of UAHC. The escrow agreement states:

   - UAHC shall escrow with TennCare the sum of $420,500. In depositing such amount into escrow, UAHC specifically denies that it has any way breached the Contract and affirms that it is making the payment in good faith for the security of TennCare. TennCare specifically acknowledges that it has not asserted any claims against UAHC, and it is not TennCare's intent to imply or suggest that the establishment of the escrow is evidence of or should be construed as an admission of any wrongdoing by UAHC. TennCare further acknowledges that the deposit is not required under the terms of the Contract.

   - If litigation is pursued by either party, both parties agree that the escrow deposit account shall remain in full force and effect until such time that a final judgment has been rendered by a court of competent jurisdiction and the conclusion of an appeal, in any.

   As of release of this examination report, the escrow deposit for $420,500 remains in place. The TennCare Bureau has the right to avail itself of any and all remedies afforded by state and federal law and the CRA if violations are ultimately determined to exist.

C. Administrative Services Only (ASO)

As previously mentioned, the CRA between UAHC and the State of Tennessee does not currently hold UAHC financially responsible for medical claims. This type of arrangement is considered "administrative services only" (ASO) by the NAIC. Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments, thus, no provisions for IBNR are reflected on the balance sheet.

Effective July 1, 2005, the CRA was amended to include shared risk incentives for the administrative fee payments received by the plan. Section 3-10.i.3. of the CRA set ten percent of the administrative fee at risk; the ten percent (10%) will either be

earned or lost based on the plan performance. The CRA defines benchmark periods for the following shared risk incentives from which performance levels are determined:

Shared Risk Initiative
Medical Services Budget Target
Usage of Generic Drugs
Completion of Major Milestone for National Committee for Quality Assurance (NCQA)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Compliance
Non-Emergency ER Visits per 1000
Inpatient Admissions per 1000
Inpatient Days per 1000

In addition, Section 3-10.i.4. of the CRA established an additional bonus pool of 15% for each risk initiative met through July 1, 2006. Effective July 1, 2007, the bonus pool will represent twenty percent (20%) of the administrative fee.

UAHC earned additional funds from the bonus pool of $1,142,758.78 for the period July 1, 2005 through June 30, 2006, and $1,438,205.26 for the period July 1, 2006 through June 30, 2007 for favorable performance related to risk initiatives.

Although UAHC is under an ASO arrangement as defined by NAIC guidelines, the CRA requires a deviation from ASO reporting guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if UAHC were still operating at-risk. As stated in Section 2-10.h.2. of the CRA, UAHC is to provide "an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the State of Tennessee's TennCare Program." TennCare HMOs provide this information on the Report 2A submitted as a supplement to the NAIC financial statements. UAHC correctly prepared the TennCare Operating Statement as if UAHC was still operating at-risk. IBNR was included in both premiums and medical expenses.

In addition to the reclassification of marketing expenses previously dicussed in Section VI.A.7., the following deficiency was discovered in the preparation of the TennCare Operating Statement. Inpatient hospital expenses were overstated by $427,136 since these expenses were related to UAHC's Medicare line of business. UAHC amended the TennCare Operating Statement on December 12, 2007, to correctly report inpatient hospital expenses for the period January 1 through June 30, 2007. The correction did not effect reported net income or net worth because of the deviation required for reporting the TennCare Operating Statement as discussed above.

Management Comments

UAHCTN concurs with TDCI's finding. The correction was made in the amended second quarter NAIC statement filed on December 12, 2007.

D. Medical Services Monitoring

Effective July 1, 2002, the CRA requires UAHC to submit a Medical Services Monitoring Report (MSM) on a monthly basis. The MSM accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MSM. UAHC submitted monthly MSM reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MSM estimates for IBNR expenses have been reviewed for accuracy.

No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Services Monitoring Report.

E. Medicare Advantage Operations

As previously mentioned beginning January 1, 2007, UAHC began operations of a Medicare Advantage plan for eligible enrollees in Shelby County, Tennessee. The plan is offered through a contract between UAHC and the Centers for Medicare & Medical Services (CMS). Medicare Advantage plans are required to be licensed HMOs in states in which they operate but primary oversight is maintained by CMS. State's regulatory authority is preempted over most areas such as prompt payment, provider network adequacy, marketing, and other areas typically regulated by TDCI. To maintain and update its certificate of authority, the plan is required to submit to TDCI organizational documents related to the Medicare Advantage plan. Also, Medicare Advantage plans are subject to the minimum net worth requirements of the state in which they operate. The state is not allowed to tax Medicare Advantage premiums. As of June 30, 2007, enrollment in UAHC's Medicare Advantage plan was approximately 240 as compared to enrollment in TennCare operations of approximately 107,800.

Review by TDCI of UAHC's Medicare Advantage operations was limited to review of accounts that effect net worth. UAHC reported premiums of $921,158 and total medical expenses of $876,507 for Medicare operations for the period January 1, 2007, through June 30, 2007. Balance sheet accounts directly related to Medicare operations included claims unpaid of $464,567 and premiums received in advance of $278,801 as of June 30, 2007. As previously noted, the claims unpaid are supported by an actuarial opinion as of June 30, 2007. The Medicare premiums received in advance represents July 2007 Medicare premiums received in June 2007. Expanded testing of Medicare operations was not considered necessary for the current examination.

HMOs are required to file notice and obtain the Commissioner's approval prior to any

material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). On August 6, 2007, UAHC executed only for the Medicare Advantage plan membership an excess insurance policy. This stop loss policy pays for medical expenses exceeding the agreed upon amount defined in the policy. This particular contract represents an excess or aggregate insurance policy as defined in Tenn. Code Ann. § 56-32-203(d). The plan failed to submit the policy to TDCI for prior approval as required by Tenn. Code Ann. § 56-32-203(c)(1).

Management Comments

UAHCTN concurs with TDCI's finding. The material modification was submitted on January 16, 2008.

F. Schedule of Examination Adjustments to Capital and Surplus

No examination adjustments were considered necessary to reported net worth on the amended 2007 NAIC Second Quarterly Statement submitted December 12, 2007.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1) and Section 2-18. of the CRA. The statute mandates the following prompt payment requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been

> either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-226(b)(1) by testing in three-month increments data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. If a TennCare MCO fails to meet the prompt pay standards in any of the three months tested, TDCI, at a minimum, requires claims data submissions on a monthly basis for the next three months to ensure the MCO remains compliant.

The prompt pay testing results for the examination period as well as through current testing by TDCI are as follows:

	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2007	87%	98.7%	**No**
February 2007	96%	99.7%	Yes
March 2007	98%	99.3%	**No**
April 2007	98%	100.0%	Yes
May 2007	100%	100.0%	Yes
June 2007	100%	100.0%	Yes
July 2007	98%	100.0%	Yes
August 2007	100%	99.9%	Yes
September 2007	100%	100.0%	Yes
October 2007	98%	100.0%	Yes

UAHC processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for claims processing requirements for the months of February 2007 and April through October, 2007. However, UAHC did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the months of January and March 2007. TDCI assessed and UAHC paid an administrative penalty in the amount of $10,000 in violation of Tenn. Code Ann. § 56-32-226(b)(1).

Management Comments

UAHCTN concurs

B. Determination of the Extent of Test Work on the Claims Processing System

Several factors were considered in the determination of the extent of testing performed on UAHC's claims processing system.

The following items were reviewed to determine the risk that UAHC had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints or independent reviews on file with TDCI related to inaccurate claims processing
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims payment accuracy reports
- Review of internal controls
- Follow-up to previous medical claims overpayment reviews

As noted below, TDCI discovered weakness related to UAHC's follow-up to errors discovered in the claims payment accuracy results. Additionally, as a result of claims testing in the previous examination, separate medical claims overpayment reviews for the periods May 1, 2002 through June 30, 2005, and July 1, 2005 through June 30, 2005 were required. Below are discussions of the final results of both medical claims overpayment reviews. In addition, testing was expanded to review all of the errors identified in the medical overpayment review for the period July 1, 2005 through July 1, 2006, to assess if UAHC has addressed the errors for the current examination period.

C. Follow-up to Previous Medical Claims Overpayment Reviews

The prior examination of UAHC for the period January 1 through December 31, 2004, revealed significant medical claims overpayments. UAHC agreed to a separate medical claims overpayment review performed by a TDCI contracted claims consultant for the period May 1, 2002, through June 30, 2005. An additional medical claims overpayment review was completed by the same consultant for the period July 1, 2005, through June 30, 2006.

In the initial medical claims overpayment review for the period May 1, 2002 through June 30, 2005, claims overpayments by UAHC totaling $5,515,225 were identified. UAHC disputed this total and, after the release of the previous examination report, TDCI agreed to reduce the claims overpayment amount by $1,289,291.33 to $4,225,933.67. Of this amount, UAHC recouped from providers and returned to TennCare $3,215,784.91. For the remaining $1,010,148.76, an escrow account established between UAHC and TennCare was utilized to return the total medical claims overpayments to TennCare.

For the period July 1, 2005 through June 30, 2006, the medical overpayment review determined overpayments of $1,132.323.92 had occurred. UAHC agreed to the

calculated overpayments and returned to TennCare the overpayments through provider recoupments.

In its previous report, TDCI made the following recommendation:

- UAHC should continue to improve claims payment accuracy percentages.
- Monitoring of the claims processing subcontractor should be enhanced.
- Benefit rules and claims processing system logic should be consistently and correctly applied.
- UAHC should ensure that all fee tables and reimbursement methodologies are accurately configured in Vestica's claims processing system.

As part of the current examination, testing was expanded to determine if UAHC has addressed the issues identified in the July 1, 2005 through June 30, 2006 medical claims overpayment review.

Follow-up to 2006 Medical Claims Overpayments Review

For each of the error types discovered in the medical claims overpayment review for the period July 1, 2005 through June 30, 2006, TDCI requested UAHC to indicate if research was performed to determine if the error has continued, if enhancements have been made to the claims processing system to prevent the error from occurring, and whether any additional recoupments were required. The responses by UAHC and the claims processing subcontractor, Vestica, are listed below and were reviewed by TDCI. Evidence was provided which indicates UAHC and Vestica are addressing previous claims payment issues through system enhancements and changes to processing procedures. Audits related specifically to the claims overpayment issues were performed and recoupments have been made.

In addition to system and procedural enhancements, UAHC has contracted with an external accounting firm to perform pricing accuracy reviews of claims processed. UAHC provided the results of the last external audit for claims processed in March 2007. The review examined all facility claims against contracted rates and confirmed that the 2.5% rate increase mandated by the TennCare was also paid. For $4,679,630.33 in total payments tested, the audit revealed errors totaling $27,375.72 or an error rate of less than 1%. The claims processing subcontractor is allowed to review and respond to the results of the external audit. Other audits include a coordinated effort between UAHC and Vestica to verify the accuracy of provider contracts loaded in the claims processing system.

TDCI also noted the improvements in claims payment accuracy testing performed by UAHC's internal audit. The prior examination by TDCI found that although the claims payment accuracy testing by UAHC was correctly identifying errors, UAHC did not react when the errors were discovered. The previous finding by TDCI noted:

The errors identified by UAHC were the result of improper establishment of the claims processing system payment logic. Testing should have been expanded immediately to determine if other claims paid applied similar incorrect system payment logic. As a result of this failure to follow-up on incorrect system payment logic, material overpayments have occurred.

Evidence was found during the current examination that as errors are identified by internal audit, UAHC researches to determine if other similar payment errors have occurred. UAHC works with Vestica to determine if recoupments are required and if additional enhancements to the system or procedures are necessary.

In summary, the follow-up review by TDCI to prior medical overpayment issues noted UAHC and Vestica have worked to address previous issues through system and procedural enhancements. Recoupments have been made when additional overpayments were discovered. Although the current examination did discover claims errors through claims processing testing, TDCI has found that UAHC has become more responsive to addressing claims payment errors and correcting or recouping erroneous payments when necessary. TDCI does not recommend a separate medical claims overpayment review. UAHC should perform reviews periodically that are targeted at all of the issues identified in the prior medical overpayments review. TDCI's testing and UAHC detailed responses to previous error types are discussed below.

Summary of Prior Medical Overpayment Review Results

The following is a summary by error type of the total overpayments discovered during the review for the period July 1, 2005 through June 30, 2006:

A. Pricing Accuracy	$ 99,146.15
B. Payment Accuracy	298,734.20
C. Coordination of Benefits	307,092.64
D. Duplicates	427,350.93
Total	$1,132,323.92

A. Error Type: Pricing Accuracy

1. Issue: Global Payments

The prior review noted overpayments were identified for hospitals whose contracted reimbursement for outpatient procedures was based on a percentage of the 2001 Medicare fee schedule. The pricing error occurred when the facility performed the technical component of a procedure and a physician performed the professional component, or interpretation, and billed on a CMS1500 claim form. Because the hospitals do not bill with a 'TC' modifier indicating only the technical component of a procedure was performed, the claims processing system was pricing the procedures at the global rate which encompasses both the technical and professional components. Therefore, the hospital was paid for performing and interpreting

the procedure, and then the interpretation fee was paid again when the physician claim was paid.

TDCI follow-up for the current examination:

Since the prior claims review, has UAHC researched the billing and payment of the global rate to the facility when a professional claim exists and paid the professional component?

UAHC/Vestica response:

Yes

TDCI follow-up for the current examination:

Were any enhancements made to the system to catch these overpayments?

UAHC/Vestica response:

1. TC Modifiers for Hospital Outpatient Services UB92 Claims: Vestica Systems uses the MEDICARE PART B TENNESSEE - 2001 FEE SCHEDULE and the Medicare Clinical Laboratory Fee schedule to obtain rates. If the CPT code is not in the 2001 schedule, system looks for the code in the next year until there is pricing. If there is no established pricing-rate for the CPT code by Medicare, the code is sent to UAHCTN for pricing.

2. UAHC Business rules for Vestica were revised and updated to direct payment for all Hospital Outpatient Services (Place of Service 22 & 23) UB92 Claims for labs, x-rays and designated procedures under the established TC rates unless the Facility/Provider Contract specifies to pay the Global Rate; or if there are specific rates based on the contract, for example: For one provider and the Non-Par Hospital fee schedule have specific flat rates for CT and/or MRI codes.

3. All Non-par hospitals are reimbursed based on Medicare TC Modifier Rates.

TDCI follow-up for the current examination:

Have any amounts been recouped or what are the results of any separate reviews of this issue?

UAHC/Vestica response:

External audits revealed that claims were paid incorrectly in March and the claims were adjusted on the June 21, 2007 remittance advice for one provider totaling approximately $18,800.

2. Issue: Ancillary Charges

The prior review noted overpayments were identified on inpatient claims where payments were made on revenue codes other than room and board codes. Certain ancillary inpatient charges were paid that should have been included in the contracted per diem.

TDCI follow-up for the current examination:

Since the prior claims review, has UAHC researched if the system correctly does not pay ancillary charges when the claim pays per diem?

UAHC/Vestica Response:

Yes.

TDCI follow-up for the current examination:

Were any enhancements made to the system to catch these overpayments?

UAHC/Vestica response:

1. Yes.
2. The system edits were reprogrammed to price inpatient claims on the inpatient room and board charges only – The edit is set to only pay revenue codes 100-219 and all additional lines are programmed to price at $0.
3. The system enhancements were made prior to July 1, 2006. Note that there were no overpayments or errors related to this issue on the last audit.
4. No additional findings of this type have been made during both external and internal audits for facility claims.

TDCI follow-up for the current examination:

Have any amounts been recouped or what are the results of any separate reviews of this issue?

UAHC/Vestica response:

No additional adjustments or recoupments have been made for findings of this type during both external and internal audits for facility claims.

B. Error Type: Payment Accuracy

1. Issue: Fee-for-Service Paid for Capitated Services

The prior review noted overpayments were identified where claims were being paid fee for service when they actually fell under a capitation agreement.

TDCI follow-up for the current examination:

Since the prior claims review, what enhancements were made to the system to correctly pay capitated claims?

UAHC/Vestica response:

UAHCTN-Vestica maintains a table of all capitated providers which is reviewed monthly for providers that join and leave group practices to ensure providers are programmed to the group as capitated. Post check run audits are performed for any payments for capitated services to ensure they are paid at zero dollars.

TDCI follow-up for the current examination:

Have any amounts been recouped or what are the results of any separate reviews of this issue?

UAHC/Vestica response:

Yes. External Audit performed August 1, 2007 revealed that for a particular tax identification number for paid dates April 5, 2007 to July 31, 2007 the provider was paid fee-for-service for capped services. For one provider, we changed tax identification for an added location. Recoupments were made in the amount of $8,140.00.

2. Issue: Emergency and observation room paid for an inpatient claim

The prior review noted overpayments were identified where emergency room (ER) and observation claims were paid when an inpatient claim was also paid for the same date of service.

TDCI follow-up for the current examination:

Since the prior claims review, has UAHC researched if the system correctly does not pay ER or observation lines when the claim pays per diem?

UAHC/Vestica response:

Yes.

TDCI follow-up for the current examination:

Were any enhancements made to the system to catch these overpayments?

UAHC/Vestica response:

1. Yes, the system queries for any inpatient claim that is in the current check-run that has an associated 400 revenue code indicating an ER claim. The query pulls in the date and the admit hour. The two services fall out for manual review. If the admit hour is within 24 hours, the ER claim is denied or adjusted.

2. For paid ER and Observation services the system also runs a second query in the check run to identify associated Inpatient claim submitted within the 24 hour period. Claim would fall out for a manual review. Service would then deny for the ER or observation claim in the current check run for part of the global.

TDCI follow-up for the current examination:

Have any amounts been recouped or what are the results of any separate reviews of this issue?

UAHC/Vestica response:

Audit performed on July 27, 2007. No additional overpayments were discovered from audit findings both external and internal for this type of overpayment/error.

3. Issue: Well Baby Claims

The prior review noted overpayments were identified where well baby claims billed with revenue code of 170 or 171 were not denied as included in the mother's per diem or case rate for certain facilities. As noted in the last review, UAHC does not have well baby rates in their hospital contracts and has been paying adult medical/surgical and intensive care rates. A per diem rate of $300 was established for well babies in August of 2005 through a business rule yet contracts were not amended. UAHC continues to pay adult medical/surgical rates for revenue codes 170 and 171 if a stay is authorized by UAHC and if UAHC determines the diagnosis to be indicative of a sick baby.

TDCI follow-up for the current examination:

Please show the enhanced edits that were put in place since the prior claims review?

UAHC/Vestica response:

- There are system edits in place now to have all claims with revenue codes 170-171 fall out for manual cross-reference review with mother's claims. System edits also kicks out all claims filed with temporary identification numbers starting with 888 for manual review to ensure that claims are denied and not paid separately.
- UAHCTN provided additional training for Case Managers on the proper way to code for nursery services using the appropriate terms and Revenue Codes. UAHCTN also discontinued using the term "WBN" well baby nursery.

TDCI follow-up for the current examination:

Have any amounts been recouped or what are the results of any separate reviews of this issue?

UAHC/Vestica response:

Yes, June 28, 2007 for $18,286.34.

4. Issue: Hospital Bill Types 115 and 135

Inpatient and Outpatient claims with a bill type ending in '5' were submitted to UAHC for review. The '5' in the last digit of the bill type indicates a "late charge." UAHC had previously paid the contracted inpatient per diem or emergency room case rate yet was paying additional charges at a percentage of billed charges. These additional late charges should have been considered already paid under the per diem or case rate. In addition, late well baby charges were paying at a percentage of billed charges yet the original claim was denied as included in the mother's per diem or case rate.

TDCI follow-up for the current examination:

Please provide the enhancements made to the system to catch these overpayments?

UAHC\Vestica response:

- A new audit report was developed to check all 115 and 135 bill types
- UAHCTN no longer accepts UB92 claims for late charges with Type of Bill (TOB) 125, 135, 145, or 765. Providers/Facilities must submit adjusted claim or (corrected claim).

TDCI follow-up for the current examination:

Have any amounts been recouped or what are the results of any separate reviews of this issue?

UAHC/Vestica response:

Review of Bill Type 135 from July 1, 2006 through June 14, 2007 discovered $262.00.

C. Error Type: Coordination of Benefits

1. Issue: Medicare Coordination of Benefits (COB) Physician Claims

The prior review noted overpayments determined that UAHC was not coordinating benefits correctly with Medicare for physician claims. The overpayments resulted because UAHC paid the difference between UAHC's allowable and what Medicare had paid (disregarding deductibles and coinsurance) even if Medicare had covered the entire service.

TDCI follow-up for the current examination:

Please provide an explanation for the current logic to pay COB claims and provide examples?

UAHC\Vestica response:

- Members classified as State Aid Code 17, State Aid Code 77, Medicare Part A or Medicare Part B must have Medicare's Summary Notice (MSN) attached to their claim or the claim is denied. Exceptions to these denials are only for Medicare non-covered service. If the MSN is attached, Vestica captures any payments or denial codes per that MSN and processing according to business rules 5 and 55. For example: a facility claim with an MSN with denial code 26 or 27 will be paid because the member does not have proper Medicare coverage for the claim on that date of service. On the professional side, HCFA 1500, a list of claims with an MSN payment of less than $0.10 and a member classified as 17/77 or A/B is generated and each of those claims is manually reviewed.
- Business Rules were updated to provide clear instructions that Vestica can only process and pay claims for Dual eligible Members that have an attached MSN i.e. Remittance Advice (RA) from Medicare indicating that the service is non-covered or benefits are exhausted and is the Member's Liability.
- In cases where member benefits are exhausted, Vestica should then coordinate the benefits and pay only UAHC's allowable for the service. Medicare's Summary Notice (MSN) RA must be attached before the claim is processed and the benefits must be exhausted or a Medicare non-covered service before payment can be made.

TDCI Follow-up for the current examination:

Have any amounts been recouped or what are the results of any separate reviews of this issue?

UAHC/Vestica response:

- Yes, COB reviews are performed monthly.
- Major Review of all claims paid for Dual eligibles classified 17 & 77 started October 31, 2007. Not complete yet. Completion target date January 5, 2008.

2. Issue: Medicare Coordination of Benefits (COB) Facility Claims

The prior review noted overpayments were identified. UAHC did not coordinate Medicare benefits correctly for the facility claims. The overpayments resulted because UAHC paid the difference between UAHC's allowable and what Medicare had paid (disregarding deductibles and coinsurance) even if Medicare had covered the entire service.

TDCI Follow-up for the current examination:

Please provide an explanation for the current logic to pay COB claims and provide examples?

UAHC\Vestica response:

- System/program is run to bump up against the Product ID of either 1030/1031 in our file and then proceeds as follows:
  1. Identify claims with an MSN or EOB attached which are flagged to prevent paying at the end of each check run.
  2. Claims Identified with revenue codes 170-174 and 650-659 are adjudicated and paid (newborn and hospice)
  3. Identify claims with A0428 and A0425 (Ambulance) and these are paid (ambulance)
  4. If the above criteria are not met, the claim is denied as "Member has Medicare Part (A or B).
- Members classified as State Aid Code 17, State Aid Code 77, Medicare Part A, Medicare Part B must have MSN's attached to their claim or it is denied unless the code is a Medicare non-covered service. If the MEOB is attached, Vestica captures any payments or denial codes per that MSN and processes according to business rules 5 and 55. For example, a

facility claim with an MEOB with denial code 26 or 27 will be paid because the member does not have proper Medicare coverage for the claim on that date of service. On the professional side, a list of claims with an MSN payment of less than $0.10 and a member classified as 17/77 or A/B is generated and each of those claims is manually reviewed.

TDCI Follow-up for the current examination:

Have any amounts been recouped or what are the results of any separate reviews of this issue?

UAHC/Vestica response:

- Monthly post check-run audits are performed and recoupments are made monthly.

Additionally:

1. On the facility side, reviews are performed on every claim for every check that has an attached MSN or EOB.

2. Facility claims are subject to the same level of MSN/EOB review as the professional.

3. A cross-reference of all claims received through the appeal process is performed to ensure we do not erroneously recoup any claims that were approved in Appeals for COB.

4. Claims are also cross-referenced with the eligibility files. Eligibility is reviewed as of the date of service or the date paid.

Note that the 17/77 designation does not necessarily mean that the member has both Medicare Part A and Medicare Part B per the 834 files. Recent analysis performed to get an idea of how the 17/77 membership breaks out as compared to Parts A and B and found the following:

Of the 14,588 members listed as 17/77, 13,613 had both Medicare Parts A and B:

1. 248 had neither

2. 440 had Part B, but not Part A

3. 287 had Part A, but not Part B

3. Issue: Medicare Benefits Exhausted

During the prior review, UAHC was asked by TDCI to research payments on 50 claims for which the eligibility file indicated the members were Medicare

eligible. There was no coordination of benefits on these claims. UAHC paid the claims based on UAHC fee schedules. UAHC researched Medicare EOBs for these claims to determine if the claims were billed to Medicare before UAHC made payment on the claims. UAHC responded that all 50 claims were paid correctly. Medicare had not covered the claims because benefits had been exhausted, the member was not eligible for the Part A or Part B that covered the service billed, or the service was not covered by Medicare.

TDCI Follow-up for the current examination:

Does UAHC/Vestica have a listing of Medicare denial codes with a crosswalk on which codes are considered a denial which UAHC would never pay even if Medicare denied?

UAHC/Vestica response:

Yes. This would be the cross-reference of the non-covered exclusions for TennCare listing. Otherwise:

1. All reviewers have a copy of the Medicare exception codes to assist in the coordination and determination of paying the claims. Listing utilized: *http://dese.mo.dov/divspeced//Finance/PDF/MedicareClaimDenialCodes.pdf*

2. Exceeds maximum, non-covered service, etc. type codes are marked to pay.

3. Service before or after coverage are marked to pay.

D. Duplicates

1. Issue: Duplicate Physician Claims

The prior review noted overpayments for duplicate payment of physician claims by identifying multiple claims that were paid with the same date of service, social security number, and physician.

TDCI Follow-up for the current examination:

How has the duplicate logic been enhanced since the prior claims review?

UAHC/Vestica response:

1. System logic was rewritten to let the system perform the denials instead of the user/processor.

2. The new process allows the system to deny the claim and the user overrides the denial if appropriate. The Processor/user still has the option to deny additional services if appropriate.

3. Removed some of the "exact" match criteria such as billed amount and quantity which previously allowed claims to slip by duplicate edits. If elements were not exactly the same, the claim would not deny. Revised the status on the paid claims instead of the dollars paid, which caused claims to be paid in error in the past.

4. Also added the code message to indicate which claim the duplicate is denying against. By indicating this to the provider, it has reduced the number of resubmitted duplicates.

UAHC/Vestica also provided an analysis indicating an increased identification of duplicate claims with increases of 39% for facility claims and 41% for physician/professional claims since the last quarter of 2006.

TDCI Follow-up for the current examination:

Have any amounts been recouped or what are the results of any separate reviews of this issue?

UAHC/Vestica response:

Reviews have been conducted both internally and externally. Internal audit performed on March 14, 2007 resulted in professional recoupments in the amount of ($14,433.84).

2. Issue: Duplicate Inpatient Claims

The prior review noted overpayments for duplicate payment of inpatient claims by identifying multiple claims that were paid with the same social security number and admission date.

TDCI Follow-up for the current examination:

Please provide narrative on all enhanced duplicate logic since the prior claims review?

UAHC/Vestica response:

UAHC/Vestica response is the same as provided in previous issue for duplicate physician claims.

TDCI Follow-up for the current examination:

Have any amounts been recouped or what are the results of any separate reviews of this issue?

UAHC\Vestica response:

Yes, after the enhanced logic was completed:

1. $41.56 on March 29, 2007
2. $32.90 on May 3, 2007
3. $121.88 on February 15, 2007

D. Claims Payment Accuracy Report

Section 2-9. of the CRA requires that 97% of claims are paid accurately upon initial submission. UAHC is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

UAHC reported the following results for calendar year 2007:

	Results Reported	Compliance
First Quarter 2007	97.67%	Yes
Second Quarter 2007	97.00%	Yes

During the examination period, UAHC was in compliance with Section 2-9 of the CRA.

1. Procedures to Review the Claims Payment Accuracy Reporting

The review of the claims processing accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the second quarter 2007 claims payment accuracy report. In addition, 20 claims deemed correctly processed by UAHC were selected at random by TDCI from UAHC's second quarter 2007 claims payment accuracy report for review. This review included verification that the number of claims selected by UAHC constituted an adequate sample to represent the population. The selected claims were reviewed to determine that the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation were compared directly to the actual report filed with TennCare. Also, all claims identified in the report with errors were reviewed to ensure the errors have been corrected.

2. Results of Review of the Claims Payment Accuracy Reporting

The following deficiencies were noted during the review of the claims payment accuracy reports.

- TDCI recommends UAHC develop a more formalized process to resolve system and manual errors. The process should include documentation that all claims related to error issues were researched, approved by appropriate personnel and the results of recoupments or additional payments documented. The subcontractor should provide affirmation that the problem was corrected through the claims processing system.

  Management Comments

  UAHCTN concurs with TDCI's findings. However, there is a formal process in place which includes documentation that all claims related to error issues are researched and signed off by the appropriate personnel (Director of Provider Services, Vestica's CFO and UAHCTN. The results of recoupments or additional payments are documented. Vestica does provide affirmation that the problem was corrected through the claims processing system. As noted before in our comments, the process did not include forwarding all of the information and final audits to the Internal Auditor. The Internal Auditor is now included in this process and will be copied on all corrective actions made for errors found in her claims accuracy audits.

- UAHC and Vestica should increase controls over the loading of provider rate configurations. One of the error claims found through UAHC's internal audits found that the person responsible for provider rate configuration incorrectly entered the contract rate percentage. Additional review and approval should be performed to confirm rates are entered they agree with the terms of the executed contract.

  Management Comments

  UAHCTN concurs with TDCI's findings. However the loading error occurred due to UAHCTN conducting a complete audit of all loaded fee schedules. A UAHCTN employee made the entry error when loading the fee schedule. Vestica discovered the error. Additional reviews and sign off procedures are conducted to confirm the accuracy of loading rates. This process has been reinforced due this finding.

E. Claims Selected For Testing From Prompt Pay Data Files

Ninety claims were selected from the June 2007 prompt pay data files previously submitted to TDCI. For each claim processed, the data files included the date received, date paid, the amount paid, and if applicable, an explanation for denial of payment.

The number of claims selected for testing was not determined statistically. The breakdown by processing results of the ninety claims selected is as follows: 50 denied claims, 30 paid claims and 10 adjusted claims. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by UAHC.

To ensure that the June 2007 data files included all claims processed in the month, the total amount paid per the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

F. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in UAHC's claims processing system. Attachment XII Exhibit G of the CRA requires minimum data elements to be recorded from medical claims and submitted to TennCare as encounter data. Original hard copy claims were requested for the ninety claims tested. If the claim was submitted electronically, the original electronic submission file associated with the claim was requested.

The data elements recorded on the claims were compared to the data elements entered into UAHC's claims processing system. A discrepancy was noted for one of the ninety claims selected for testing by comparing the information submitted on the claims and the data recorded in UAHC's system. The date of service was incorrectly entered into the claim processing system which also resulted in an incorrect denial for untimely filing discussed below. (P10)

Management Comments

UAHCTN concurs with TDCI's findings.

G. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected.

For five of the ninety claims selected for testing, the following processing errors were noted:

- For one claim, UAHC incorrectly denied the claim with the explanation reason "invalid modifier". The modifier reported by the provider was appropriate for the medical procedure. UAHC reprocessed and paid the claim on December 6, 2007.

- For one claim, code J0886 reported by the provider with procedure code Q4081. Procedure code J0886 was invalid for the date of service and should have been denied. Additionally, since UAHC changed the procedure code on the claim, a second claim was paid for the same service in error. UAHC recouped the duplicate payment on November 15, 2007. UAHC should research other payments for these procedure codes to verify duplicate payments have not occurred.
- As previously mentioned for one claim, the date of service was incorrectly entered into the claims processing system which resulted in an incorrect denial for timely filing.
- For one claim, UAHC incorrectly paid a duplicate claim for the same member, and date of service on October 25, 2007. UAHC recouped the overpayment on November 21, 2007. UAHC noted the duplicate was the result of the submission of an electronic claim and a paper claim for a transplant services. UAHC notes the error was caught during internal audit and review. UAHC should work with Vestica to develop procedures to eliminate duplicate payments when both an electronic and paper claim is submitted for transplant services.
- For one claim, UAHC's denial of the claim was appropriate but the explanation reason communicated to the provider "no reimbursement information found for service" did not reflect the reason the claim denied. The reason the claim denied was that the provider had not submitted all documents related to credentialing.

Management Comments

UAHCTN concurs with TDCI's findings.However, effective 1/01/07, a new HCPC Code was established for an injection of epoetin alffa, 100 units for ESRD patients on dialysis. HCPC code J0886 can no longer be used; it has been replaced by Q4081. Vestica updates the CMS fee tables quarterly. System glitch (which has since been repaired for this code) overrode the J code and changed it to the new Q code and paid for this one claim. The second submission did not catch for duplicate because the code was different (the original J0886). Funds were recouped on 11/15/2007 for duplicate payment. Audit was performed and no other claims were affected by this system error.

H. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly.

For two of the ninety claims selected for testing, the following pricing errors were noted:

- For one claim, UAHC underpaid a hospital provider because the claim was paid based on a per diem instead of the contracted case rate.
- For one claim, the payment amount by other insurance was incorrectly entered resulting in an overpayment of $0.83.

Management Comments

UAHCTN concurs with TDCI's findings

I. Copayment Testing

The purpose of testing copayment is to determine if enrollees are subject to out-of-pocket payments for certain procedures, if out-of-pocket payments are within liability limitations, and if out-of-pocket payments are accurately calculated. TDCI requested a report listing of the top 100 enrollees based on copays accumulated for the examination period. For five of the enrollees listed, the copays applied to the enrollees were confirmed for accuracy for the examination period. No discrepancies were noted in the review of these claims.

J. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

The examiners had access to the online remittance advices for the claims selected for testing. Comparison of the payment and/or denial reasons per the claims processing system to the information communicated to the providers was reviewed. No discrepancies were noted between the claims payment per the claims processing system and the related information communicated to the providers.

K. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to: (1) verify the actual payment of claims by UAHC; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested cancelled checks for five of the ninety selected claims for testing. UAHC provided the cancelled checks. The check amounts agreed with the amounts paid per the remittance advice and no pattern of significant lag times between the issue date and the cleared date was noted.

L. Pended and Unpaid Claims Testing

The purpose of analyzing pended claims is to determine if a significant number of claims are unprocessed and as a result a material liability exists for the unprocessed claims.

The pended and unpaid data file submitted to TDCI for the most recent prompt pay test work for the month of October 30, 2007 indicated that no claims exceeded 60 days. No evidence exists of a material liability for claims over 60 days.

M. Electronic Claims Capability

Section 2-9.m.3 of the CRA states, “The CONTRACTOR shall provide the capability of electronic billing…” The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

UAHC has demonstrated the capability to accept claims electronically. UAHC has indicated it has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes.

N. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures by UAHC ensure that all claims received from providers are either returned to the provider where appropriate or processed by the claims processing system.

Section 2-10.s. of the CRA between UAHC and TennCare requires the performance of a Type II SAS 70 audit if a non-affiliated organization processes claims that represent more than 20% of TennCare medical expenses of UAHC. UAHC contracts with UHY, LP, Detroit, Michigan, to perform a SAS 70 Audit of the claims processing subcontractor, Vestica. In a Type II report, the service auditor will express an opinion on (1) whether the service organization's description of its controls presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation as of a specific date, and (2) whether the controls were suitably designed to achieve specified control objectives, and (3) whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period specified.

One of the control objectives of the SAS 70 audit was to ensure Vestica has proper tracking mechanisms to ensure paper claims are received and entered timely into the claims processing system. The auditor judgementally selected thirty-seven claims for testing to confirm the control activities that claims are date stamped by the mailroom each day when received from the courier and claims are counted and totaled by the plan and the totals are input into a claims inventory database. The auditor noted no exceptions for these control objectives.

TDCI has relied upon the testing performed in the SAS 70 audit for mailroom and claims inventory controls.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

Provider complaints were tested to determine if UAHC responded to all provider complaints in a timely manner. Ten provider complaints were judgmentally selected from a list provided by UAHC. Tenn. Code Ann. § 56-32-226 states:

> The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request with an estimated time frame in which the health maintenance organization will complete its investigation and provide a complete response to the provider. If the health maintenance organization determines that it needs longer than thirty (30) calendar days to completely respond to the provider, the health maintenance organization's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the health maintenance organization.

Ten provider complaints were selected for testing from provider complaint logs to determine if responses are timely. For one of the ten provider complaints tested, the provider was informed of the resolution to the complaint 62 calendar days after receipt of the provider's reconsideration request. The additional time to completely respond was not agreed upon in writing by the provider and UAHC as required by UAHC's policy and Tenn. Code Ann. § 56-32-226.

Management Comments

UAHCTN concurs with TDCI’s findings.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers

of the correct procedures to follow in the event of a disputed claim. UAHC submitted

the provider manual and TDCI approved the July 2006 version on September 1, 2006.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include, but are not limited to: standards of care, assurance of TennCare enrollees rights, compliance with all federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the CRA between UAHC and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of the CRA requires that all provider agreements executed by UAHC shall at a minimum meet the current requirements listed in Section 2-18.

Seven provider contracts were judgmentally selected and reviewed to determine compliance with CRA requirements.

UAHC has submitted for prior approval to TDCI a provider contract template which includes a standard compensation exhibit. Review of executed provider contracts found that the approved standard compensation exhibit was not always utilized. For example, the compensation exhibits with capitated primary care providers include additional compensation terms beyond the approved standard compensation exhibit. All compensation terms should have been submitted to TDCI for prior approval as required by Section 2-9 of the CRA and Tenn. Code Ann. § 56-32-203(c)(1). After fieldwork, UAHC submitted for approval additional rate exhibits.

Management Comments

UAHCTN concurs with TDCI's findings.

Section 2-18. of the CRA between UAHC and TennCare requires specific language requirements for provider agreements. For five of seven provider agreements

selected for testing, not all of the contract language requirements were included in the executed contracts. The missing language requirements include:

j. Specify unreasonable delay in providing care to a pregnant member seeking prenatal care will be considered a material breach of the network provider's contract with the CONTRACTOR and include definition of unreasonable delay as described in Section 2-3.r.1.

l. Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the agreement or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions).

All agreements shall include a statement that as a condition of participation in TennCare, enrollees shall give the TENNCARE Bureau, TENNCARE, the Office of the Comptroller, and any health oversight agency, such as OIG, MFCU, HHS OIG, and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Comptroller personnel, including, but not limited to, the OIG, the MFCU, the HHS OIG and the DOJ.

Require that medical records requirements found in Section 2-9.i be included in provider agreements and that medical records be maintained at site where medical services are rendered. Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.

The provider agreement must contain the language described in Section 2-12 and 2-13 of this Agreement;

m. Provide that TENNCARE, U.S. Department of Health and Human Services, and Office of Inspector General Comptroller, OIG, MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality,

appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of PHI to health oversight agencies, including, but not limited to, OIG, MFCU, HHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, MFCU, HHS OIG, DOJ, Office of the Comptroller, may use these records and information for administrative, civil or criminal investigations and prosecutions;

p. Specify CONTRACTOR's responsibilities under its participation agreement, including but not limited to, provision of a copy of the member handbook whether via web site or otherwise and requirement that CONTRACTOR notice a provider of denied authorizations;

ff. Include a conflict of interest clause as stated in subsections (a) and (c) of Section 4-7, Gratuities clause as stated in 4-11 and Lobbying clause as stated in 4-12 of this Agreement between the CONTRACTOR and TENNCARE;

ll. Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider will comply with the appeal process, including but not limited to the following:

1. assisting an enrollee by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review; and
2. require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.)

UAHC provided the following responses:

- For CRA Section 2-18.l., the majority of the language for CRA Sections 2-12 and 2-13 is found on page 10 & 11 of the Provider Manual. This agreement references the Provider Manual. Language does list all of the agencies. Language and agencies also listed on Page 123 of the provider manual under Fraud and Abuse program. The provider agreement does not have the

  investigation, prosecution and termination termination language and where medical services rendered language.

- For CRA Section 2-18.m, The agencies are listed in the Provider Manual

under Access to Confidential Information pages 10 & 11. All of the agencies are listed. The use of records for investigations and prosecutions are not listed but the agencies are.

- For CRA Section 2-18.ff., the COI form was only mailed to providers with older agreements. Contract did not need a Conflict of Interest form for the newer contracts that refer to the Manual. COI Language is in the Manual on Page 122.

- For CRA Section 2-18.ll., located in the Provider Manual on pages 50-53.

UAHC indicates the provider manual contains four of the missing CRA Section 2-18 language requirements. Since the provider manual is incorporated by reference for these contractual terms, UAHC is required to comply with CRA Section 2-18.cc. which states:

> Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);

UAHC should maintain proof of notice of rejection each time that the provider manual is updated for CRA Section 2-18. language requirements.

Management Comments

UAHCTN concurs with TDCI that the Plan should maintain proof of notice of rejection each time that the provider manual is updated for CRA Section 2-18. Plan will implement this requirement with all future Provider Manual updates.

Provider Capitated Payments

Examiners tested capitation payments to providers during the examination period January 1 through June 30, 2007 to determine if UAHC complied with the payment provisions set forth in its capitated provider agreements. Review of payments to

capitated providers indicated that all payments were made per the provider contract requirements in a timely manner.

D. Subcontracts

HMOs are required to file notice and obtain the Commissioner's approval prior to any material modification of operational documents including subcontracts in accordance with Tenn. Code Ann. § 56-32-203(c)(1). The following deficiencies were noted in

review of subcontracts:

- UAHC executed a subcontract for a nurse help line without prior approval of the TennCare Bureau and TDCI in violation of Sections 2.9.f. and 2-17.c. of the CRA and Tenn. Code Ann. § 56-32-203(c)(1).

- UAHC amended the administrative service agreement with Vestica for claims processing services. The amendment added the processing for the Medicare line of business and adjusted the compensation to Vestica. Since the amendment included more than a change in compensation amount, the amendment should be submitted to TDCI for approval per Tenn. Code Ann. § 56-32-203(c) (1).

Management Comments

UAHCTN concurs with TDCI and the subcontracts will be submitted to TDCI for approval.

E. Non-discrimination

Section 2-24. of the CRA requires UAHC to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various UAHC staff and a review of policies and related supporting documentation, UAHC was in compliance with the reporting requirements of Section 2-24. of the CRA.

F. Stabilization

Section 3-10.h.2(a) of Amendment 4 to UAHC's CRA requires UAHC to comply with the following:

> The CONTRACTOR shall reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002, for covered services as defined in Section 3-10.h.2(j), unless otherwise directed by TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider.

UAHC's management confirmed compliance with all stabilization requirements. During testing of financial, claims processing, and provider contracts, TDCI noted no instances of non-compliance with this CRA requirement.

G. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of

information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

UAHC's internal auditor reports to the CFO and the board of directors. The internal audit department issues and plans focused reviews of compliance with CRA requirements. The internal audit staff also prepares the claims payment accuracy report as required by the CRA.

H. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…" UAHC has complied with this statute.

I. Behavioral Health Organization (BHO) Coordination

UAHC was in compliance with Section 2-3.c.2 of the CRA whereby effective July 1, 2002, "claims for covered services with a primary behavioral diagnosis code, defined as ICD 9-CM 290.xx- 319.xx'' are submitted to UAHC for timely processing and payment.

UAHC is required to refer unresolved disputes between the HMO and BHO to the State for a decision on responsibility after providing medically necessary services. UAHC did not have any ongoing disputes with the BHO.

J. Contractual Requirements for ASO Arrangements

As previously mentioned, effective May 1, 2002, UAHC's CRA was amended so that UAHC would operate as an ASO. As a result, the provisions tested below are requirements for transactions with dates of service after May 1, 2002.

1. Medical Management Policies

Section 2-2.s. of the CRA requires UAHC to comply with the following as it relates to the TennCare line of business:

> Agree to reimburse providers for the provision of covered services in

> accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as that existed on April 16, 2002, unless otherwise directed or approved by TennCare, and to submit copies of all medical management policies and procedures in place as of April 16, 2002, to the State for purpose of documenting medical management policies and procedures before final execution of this Amendment.

UAHC's management has confirmed compliance with the requirements described above. During testing of claims processing and provider contracts, no deviations to the requirement were noted.

2. Provider Payments

Section 3-10.h.2(b) of the CRA states that UAHC "shall release payments to providers within 24 hours of receipt of funds from the State." A sub sample of five cancelled checks from the ninety claims selected for testing in Section VII.D. were requested to confirm no significant lag exists between the check date and the date the check was deposited. Based on TDCI's review, UAHC has complied with this provision.

3. 1099 Preparation

Section 3-10.h.2(c) of the CRA states that UAHC "shall prepare and submit 1099 Internal Service Reports for all providers to whom payment is made." Based on TDCI's review, UAHC has complied with this requirement.

4. Interest Earned on State Funds

Section 3-10.h.2.(d) of the CRA states interest generated by funds on deposit for provider payments related to the non-risk agreement period shall be the property of the State. The interest amount earned on the funds reported on UAHC's monthly bank statement should be deducted from the amount of the next remittance request from the TennCare Bureau. Review of interest earned on funds on deposit for provider payments related to the non-risk agreement period were paid to TennCare in a timely manner.

5. Recovery Amounts/Third Party Liability

Sections 3-10.h.2.(f) and (g) of the CRA require third party liability recoveries and subrogation amounts related to the non-risk agreement period be reduced from medical reimbursement requests of the TennCare Bureau. As third party liability and subrogation amounts are recovered, UAHC should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered.

Subrogation amounts collected through June 30, 2007 totaling $409,603.87 were not returned to the State in a timely manner per Sections 3-10.h.2.(f) and (g) of the CRA. The amount collected was not reduced from the next reimbursement

request to the TennCare Bureau. A majority of the amounts collected and due to TennCare were over 90 days old. UAHC should improve procedures to promptly analyze and record these amounts into the claims processing system.

Management Comments

UAHCTN concurs with TDCI's finding. The Plan is currently implementing new processes to expedite the processing of subrogation and provider refund checks.

6. Pharmacy Rebates

Section 3-10.h.2.(f) of the CRA states that pharmacy rebates collected by UAHC shall be the property of the State. During the on-site visit, UAHC indicated no further amounts were expected from the PBM for services which ended June 30, 2003.

K. Conflict of Interest

Section 4-7. of the CRA warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to UAHC in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Conflict of interest requirements of the CRA were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with the provisions required by the CRA shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for

including the substance of CRA conflict of interest clauses in all subcontracts, provider agreements and any and all agreements that result from the CRA.

Previous Conflict of Interest Finding

As previously noted, as escrow account was funded by UAHC's parent in the amount of $420,500 related to payments made to former State Senator John Ford. In 2005, several media reports linked former State Senator John Ford to UAHC and possible violations of conflict of interest requirements of the CRA. Sections 4-7. of the CRA warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee,

subcontractor, or consultant to UAHC in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration. On April 15, 2005, United American Detroit stated it contracted with former State Senator John

Ford for consulting services to "explore expansion of its business to other southern states beyond Tennessee…" The escrow agreement states:

UAHC shall escrow with TennCare the sum of $420,500. In depositing such amount into escrow, UAHC specifically denies that it has any way breached the Contract and affirms that it is making the payment in good faith for the security of TennCare. TennCare specifically acknowledges that it has not asserted any claims against UAHC, and it is not TennCare's intent to imply or suggest that the establishment of the escrow is evidence of or should be construed as an admission of any wrongdoing by UAHC. TennCare further acknowledges that the deposit is not required under the terms of the Contract.

If litigation is pursued by either party, both parties agree that the escrow deposit account shall remain in full force and effect until such time that a final judgment has been rendered by a court of competent jurisdiction and the conclusion of an appeal, in any.

In the previous examination report, TDCI recommended that UAHC, United American Tennessee and United American Detroit implement the following procedures to enhance compliance with the CRA including conflict of interest requirements:

- Since the only HMO controlled by United American Detroit is UAHC, the TennCare plan, members of the board of directors and officers of United American Detroit should be held to the same annual reaffirmation of the code of conduct disclosures required by employees of the management company. The directors and officers of United American Detroit have the same responsibility as United American Tennessee employees to ensure compliance with all of the terms of the CRA.

- This examination report included multiple deficiencies in TennCare operations including overpayment of Federal and State dollars and failures in the monitoring of subcontractors. The board of directors and the officers of UAHC and United

  American Detroit's oversight of UAHC should focus on the correction of deficiencies in TennCare operations.

- Internal audit department should perform focused reviews to determine UAHC's compliance with CRA requirements including the conflict of interest requirements. Through internal audit, the board of directors should ensure that management adheres to internal controls established.

Current Conflict of Interest Testing

During current examination testwork, UAHC demonstrated the following efforts to ensure compliance with conflict of interest clause of the CRA:

- UAHC's Corporate Compliance Manager confirmed no instances of non-compliance with the conflict of interest have been found.
- The Corporate Compliance Manager reports directly to the president and chief executive officer.
- There are written policies and procedures in both employee and provider handbook concerning conflicts of interest.
- Annually, conflict of interest forms are completed by employees. Also, violations can be reported to the "Whistle Blower Anonymous Integrity Hotline."
- The Internal Audit Department performs reviews to determine compliance with conflict of interest requirements of the CRA.
- Members of the board of directors and officers of United American Detroit are held to the same annual reaffirmation of the code of conduct disclosures required by employees of the management company. The directors and officers of United American Detroit have the same responsibility as United American Tennessee employees to ensure compliance with all of the terms of the CRA.

As previously noted in Section VIII.C. of this report, seven contracts were selected for testing for provider contract language requirements, including conflict of interest language requirements. Two of the seven contracts did not include conflict of interest language requirements per 2-18.cc. of the CRA (UAHC's Exhibit 11, "Conflict of Interest and Lobbying")

UAHC provided the following response:

> For CRA Section 2-18.ff., the COI form was only mailed to providers with older agreements. Contract did not need a Conflict of Interest form for the newer contracts that refer to the Manual. COI Language is in the Manual on Page 122.

UAHC indicates that these provider contracts incorporate by reference the provider manual to enforce the conflict of interest language. The provider manual does include the conflict of interest language requirements. Since reliance on the provider manual is not duly signed and attached to the original agreement, UAHC must provide proof of notice of rejection per Section 2-18.cc. Section 2-18.cc. states:

> Specify procedures and criteria for any alterations, variations, modifications,

waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and

requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);

TDCI could not verify compliance with conflict of interest requirements for the two contracts since UAHC has not provided proof of notice of rejection per Section 2-18.cc.

Management Comments

UAHCTN concurs with TDCI

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of UAHC.